NO. 75-1450

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1975

IOWA DEPARTMENT OF SOCIAL SERVICES, STATE OF IOWA,

Petitioner,

vs.

WEST HEIGHT MANOR, INC.,

Respondent,

KEVIN BURNS, COMMISSIONER OF STATE OF IOWA DEPARTMENT OF SOCIAL SERVICES, AND STATE OF IOWA DEPARTMENT OF SOCIAL SERVICES,

Petitioners,

vs.

HUTCHISON NURSING HOME, INC., NEW HAVEN REST HOME, INC., GRIFFIN NURSING CENTER,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE IOWA SUPREME COURT

RICHARD C. TURNER
Attorney General of Iowa

LORNA LAWHEAD WILLIAMS
Special Assistant
Attorney General

State Capitol
Des Moines, Iowa 50319

ATTORNEYS FOR PETITIONERS

INDEX

CITATIONS

Cases: Page

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1975

NO.

IOWA DEPARTMENT OF SOCIAL SERVICES, STATE OF IOWA,

Petitioner,

vs.

WEST HEIGHT MANOR, INC.,

Respondent,

KEVIN BURNS, COMMISSIONER OF STATE OF IOWA DEPARTMENT OF SOCIAL SERVICES, AND STATE OF IOWA DEPARTMENT OF SOCIAL SERVICES,

Petitioners,

vs.

HUTCHISON NURSING HOME, INC., NEW HAVEN REST HOME, INC., GRIFFIN NURSING CENTER,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE IOWA SUPREME COURT

OPINIONS BELOW

The opinions of the Iowa Supreme Court (Appendix A and B, pp. 1a-19a, *infra*) in the two above-captioned cases are reported at 236 N.W.2d 307 and 312. A single Petition for Writ of Certiorari covering both cases is filed pursuant to Rule 23(5) of this Court, since they involve identical issues.

JURISDICTION

The Decisions of the Iowa Supreme Court were entered December 17, 1975, and an Order Granting Stay was filed on February 20, 1976, pending a decision by this Court on a Petition for Writ of Certiorari. Mr. Harry A. Blackmun of this Court entered an Order March 15, 1976, extending the time to file this Petition for Writ of Certiorari to and including April 15, 1976.

The litigation arose when the State of Iowa Department of Social Services attempted to recover that portion of State and Federal monies it had paid to Respondent nursing homes. The claim for reimbursement was made under the "reasonable cost" concept of the Federal Law in Part A of the Medicare law, 42 U.S.C. 1395f and the retroactive reimbursements rights in 42 U.S.C. 1395x(v)(1). (App. D, pp. 21a - 23a)

The jurisdiction of this Court is conferred by 28 U.S.C. 1257(3) Cf. *St. Louis & Iron Mountain Ry v. Taylor,* (1908) 210 U.S. 281 at 293.[1] Where a right under the law of the United States has been denied by a state court, "jurisdiction [is] so clearly warranted by the Constitution and so explicitly conferred by the act of Congress [it] needs no justification." Jurisdiction is also in this Court "to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use." *Rasado v. Wyman,* (1970) 397 U.S. 397, 422.

---

[1] In *St. Louis & Iron Mountain Ry,* supra, the Court at p. 293 also said:

"But it may not be out of place to say that in no other manner can a uniform construction of the statute laws of the United States be secured, so that they shall have the same meaning and effect in all the States of the Union."

The decisions upon which review is sought (Appendix A and B, pp. 1a-19a, infra), are final decisions of the Iowa Supreme Court. This is the highest court in Iowa's judicial system.

QUESTIONS PRESENTED

1. Can the decision of the state court stand which (1) interprets federal regulations in such manner as prevents the enforcement of a Congressional Act, and (2) which, contrary to the supremacy clause of the Federal Constitution, holds that state law blocks the operation of the Federal Act in a jointly administered federal-state program.

2. Whether skilled nursing homes, which accepted payments of State and Federal monies under Title 19 of the Social Security Act based upon their own established accelerated depreciation schedules, and which thereafter left the program prior to the term they set forth in their schedules, thereby receiving payments in excess of those had the straight-line depreciation method been used, can be permitted to retain the payments in view of the Congressional limitation on payments of "reasonable costs" and the requirement for "suitable retroactive corrective adjustments." (42 U.S.C. 1395f(b) and 42 U.S.C. 1395x(v)(1))

STATUTES AND REGULATIONS INVOLVED

(Appendix C-H pp. 1a - 29a)

Federal Constitution -- Article VI

United States Code:

28 U.S.C. 1257

42 U.S.C. 1395f(b)

42 U.S.C. 1395x(v) (1)

42 U.S.C. 1396a(a) (30)

Code of Federal Regulations:

20 C.F.R. 405.415(d)(1) — 1966

20 C.F.R. 405.415(d)(3) — 1970 amendment

20 C.F.R. 405.415(f) — 1966

20 C.F.R. 405.417(b) — 1966

Code of Iowa, 1973

§ 249A.4

§ 249A.4(9)

Iowa Departmental Regulations

4.12 IDR 1971

5.1 IDR 1971

Iowa State Plan

Iowa Department of Social Services Handbook for Skilled Nursing Homes

STATEMENT OF THE CASE

Respondent West Heights Manor, Inc., participated in the Medicaid program in 1968, 1969, and 1970, terminating the program in November, 1970, but providing no services after July 1, 1970. Respondents Hutchison Nursing Homes, Inc., terminated its participation in the Medicaid program February 1, 1971, New Haven Rest Home, Inc., on October 1, 1970, and Griffin Nursing Center on April 1, 1972.

The Iowa Medicaid Program is pursuant to Chapter 249A Code of Iowa, which is an enabling act to permit Iowa to receive Federal matching money to furnish medical care under the Social Security Act, Title 19. (App. F, p. 26a)

Under Iowa's State Plan, the State Regulations and "basis of payment" set forth in Iowa Department Handbook for Skilled Nursing Homes, which Handbook was submitted to HEW as part of the State Plan approved on September 27, 1967, effective as of July 1, 1967, (App. H, p. 28a) adopted the Title 18 (Medicare) formula.

Included in the packet of documents submitted to HEW containing the explanatory statement quoted by the Iowa Court, (App. D, *infra*) was the Handbook for Skilled Nursing Homes. This was approved for distribution to all nursing homes at the inception of their participation in the program and appears as part of Appendix H since it was incorporated in Iowa's State Plan.

These nursing homes received the Handbooks at the inception of their participation in the program, stating the "basis of payment" would be pursuant to "Part A of Medicare."

At the time the nursing homes entered the program, Part A of the Federal Social Security Act (Medicare), limited the facilities to payments based upon "reasonable costs" in the operation of the facility, and provided for "retroactive adjustments." (App. D, p. 22a) Also, at the time they entered the program, the Secretary of HEW had promulgated the 1966 Regulations giving the right to take accelerated but also providing for retroactive adjustment upon "disposal of assets." (App. E, p. 24a)

There was an amendment to the Regulations published August 1, 1970 (App. E, p. 25a) which specifically covered the exact fact situation here. Here, all four nursing homes had included within their "cost reports," an item for depreciation which they had computed on an accelerated depreciation schedule. Payment was made accordingly. Prior to the consummation of the "useful life" of the assets, the Respondent nursing homes, having received early depreciation based upon their schedule, terminated the program, thus depriving the Iowa Department the benefit of paying lesser depreciation in the latter years.

The Iowa Court, instead of referring to the Federal Act requiring the Secretary to make regulations which "provide for the making of" "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," relied upon the decision in *South Windsor Convalescent Homes, Inc. v. Weinberger*, which is on appeal to the 5th Circuit Court of Appeals. (Footnote 4, *infra*)

The Court then held "We interpret the Medicare formula as it existed before August 1, 1970, to include accelerated

depreciation as an allowable cost not subject to government recapture upon nursing home termination of participation in the Medicare program . . . The August 1, 1970, change was not part of the State's bargain with these plaintiffs, nor was it part of the state law and state plan under which that bargain was made and performed." (App. B, p. 18a)

REASONS FOR GRANTING WRIT

I. THE DECISION OF THE IOWA SUPREME COURT CONFLICTS WITH THE SUPREMACY CLAUSE IN ARTICLE VI OF THE UNITED STATES CONSTITUTION IN THAT IT PERMITS THE STATE LAWS TO OVERRIDE FEDERAL LAW IN AN AREA IN WHICH THE FEDERAL LAW IS PARAMOUNT, AND CONFLICTS WITH THE DECISION OF THIS COURT IN *PUBLIC UTILITIES COMM. OF CALIFORNIA VS. UNITED STATES,* (1958) 355 U.S. 534.

II. THE DECISION OF THE IOWA COURT CONFLICTS WITH THE HOLDING OF THIS COURT IN *RASADO VS. WYMAN,* (1970) 397 U.S. 397, THAT A STATE CANNOT EXPEND FEDERAL MONIES CONTRARY TO CONGRESSIONAL INTENT.

III. THE DECISION OF THE IOWA COURT CONFLICTS WITH THE DECISION IN *TEAMSTERS UNION VS. OLIVER,* (1958) 358 U.S. 283 WHEREIN CONTRACTS WERE HELD INVALID WHICH WERE MADE UNDER STATE LAW BUT IN CONFLICT WITH FEDERAL LAW AND CONGRESSIONAL INTENT.

IV. THE CASE IS OF GRAVE IMPORTANCE TO THE PUBLIC INTERESTS SINCE THE DECISION INVOLVES RECOVERY RIGHTS OF FEDERAL AND STATE'S MONIES

NOT ONLY IN THE MEDICAID BUT ALSO IN THE MEDICARE PROGRAMS AND AN EARLY DETERMINATION OF THE ISSUE IN THIS CAUSE WILL SETTLE THE ISSUE IN PENDING LITIGATION IN IOWA AS WELL AS BE DETERMINATIVE OF THIS ISSUE IN CASES CURRENTLY BEFORE THE UNITED STATES COURT OF APPEALS IN THREE CIRCUITS.

THE FEDERAL QUESTIONS ARE SUBSTANTIAL

Petitioners respectfully submit that the Iowa Supreme Court was wrong to permit Federal regulations and the Iowa law to override Congressional intent. The issues here are to be governed by the Federal Social Security Act. (42 U.S.C. 1395 etseq., being referred to as "Title 18" or Medicare)

The Iowa Supreme Court in *Hutchison*, (App. B, pp. 11a-19a, infra) while alluding to the Federal statute saying, "The State contends the right to recapture accelerated depreciation inheres in the reasonable cost concept" [of 42 U.S.C. 1395f; 42 U.S.C. 1395x(v)(1)] made no further reference thereto. The Court considered solely the HEW regulation which permitted nursing homes to select their method of depreciating assets [20 C.F.R. 405.415(d)(1)], and the amendment published in August, 1970, [20 C.F.R. 405.415(d)(3)], which expressly requires recapture of accelerated depreciation under the facts here. It made no reference to the 1966 regulations 20 C.F.R. 205.415f nor to 405.417 relating to gains on "disposal of" depreciable assets. In addition to failing to refer to the language of the Federal Act which requires the Secretary of Health, Education and Welfare (HEW) to make "suitable retroactive adjustments," the Iowa Court failed to refer to and consider the 1966 regulations covering gains or losses upon "disposal of depreciable assets," 20 C.F.R. 405.415f and 405.417.

Thus, the Iowa Court's decision permits the Federal regulations as construed to take precedence over Congressional intent as expressed in the Federal Act.

This Court consistently has recognized that the "regulations of the department cannot have the effect of amending the law. . . they cannot change its positive provisions," *U.S. vs. 200 Barrels of Whiskey,* (1877) 95 U.S. 571, 576, cited with approval among other decisions of this Court in *Miller v. United States,* (1934) 294 U.S. 435, 440.

And, the Court's decision likewise permits the State laws to take precedence over Congressional intent as expressed in the Federal Act. This also is contrary to the holdings of this Court. This Court reversed the decision of the Ohio Supreme Court in *Teamsters Union v. Oliver,*[2] (1958) 358 U.S. 283, wherein we read:

> "Since the Federal law operates here, in an area where its authority is paramount, . . . the inconsistent application of the state law is necessarily outside the power of the State. (citations) . . . Of course, the paramount force of the Federal law remains even though it is expressed in the details of a contract Federal law empowers the parties to make, rather than in terms in the enactment of Congress. (citation)."

The Iowa Court prevents the Department from recovering State and Federal monies. This is, in effect requiring Iowa to

---

[2]Also in *Teamsters Union, supra,* the court at p. 295 said:
"To allow the application of the Ohio antitrust law here would wholly defeat the full realization of the Congressional purpose. . . . Since the federal law operates here, where its authority is paramount, . . . the inconsistent application of state law is necessarily outside the power of the State. *Hill v. Florida,* 325 U.S. 538, 542-544. (other citations)"

expend money contrary to Federal law and is contrary to the previous holdings of this Court. In the Aid to Families with Dependent Children (ADC) Program this Court held that New York could not expend Federal funds "in a manner contrary to that intended by Congress." *Rasado v. Wyman, supra.* In *Ivanhoe Irrigation Dist. v. McCracken,* (1958) 357 U.S. 275, 295, the Court said:

> "a State cannot compel use of federal property on terms other than those prescribed or authorized by Congress. *Public Utilities Comm'n of California v. United States,* 355 U.S. 534 (1958). Article VI of the Constitution, of course, forbids state encroachment on the supremacy of federal legislative action."

In Part A of the Medicare Law, the Secretary of HEW was directed to make regulations which:

> "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." [42 U.S.C. 1395x(v)(1)]

And, the Secretary responded by stating the gains or losses on depreciable assets should be prorated recognizing the time the assets were used in the program. The 1966 regulations read:

> 20 C.F.R. 405.415 "(f) *Gains and losses on disposal of assets.* Gains and losses realized from the disposal of depreciable assets are to be included in the determination of allowable cost. The extent to which such gains and losses are includable is to be calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation in the program."

> 20 C.F.R. 405.417 "(b) . . . If the asset is disposed of before the expiration of its estimated useful life, the depreciation would be adjusted to the actual useful life. . . ."

The words "dispose of" apply to any situation where the owner removes the asset from the benefit of the Medicaid Program within the meaning of the Regulation, i.e., if the asset is removed from the program during its useful life before the expiration of the accelerated-depreciation schedule, a gain occurs whether it is removed for the purpose of a sale to a third person or removed for private use by the owner, and, whether participation in the program is continued or discontinued.

But the Iowa Court, if it felt that the 1966 Regulation, could not be interpreted sufficiently broad to permit recovery in accord with Congressional intent, without straining the words "disposed of depreciable assets," should have held that the 1970 amendment related back to the effective date of the Federal Act. "A statute is not made retroactive merely because it draws upon antecedent facts for its operation." *Cox v. Hart,* (1922) 260 U.S. 427, 435; *Reynolds v. U.S.,* (1934) 292 U.S. 443; *Chovan v. E.I. Dupont de Nemours & Co.,* (1963) 217 F.Supp 808.

This Court, in *Addison v. Holly Hill Fruit Products,* (1944) 322 U.S. 607, 620, when faced with the situation where it had declared a regulation invalid, remanded the case to the lower court with direction to withhold the decision until the Secretary had time to make a valid regulation saying:

> "The accommodation that we are making assumes, what we must assume, that the Administrator will *retrospectively act* as conscientiously within the bounds of the power given him by Congress as he would have done initially had he limited himself to his authority. To be sure, this will be a *retrospective* judgment, . . .

"Such an adaptation of court procedure to a remolding of the situation as nearly as may be to what it should have been initially is not unprecedented. Such was essentially the procedure which was devised to unravel the skein in *United States v. Morgan,* 307 U.S. 183, 83 L ed 1211, 59 S Ct 795." (Emphasis supplied)

In *Metlakatla Indians v. Egan,* (1961) 369 U.S. 45, this Court, citing *Holly Hill, supra,* vacated the judgment of the Supreme Court of Alaska and remanded the case there to give the Secretary of the Interior time to draw regulations. The Court of Appeals for the 5th Circuit also cited and relied upon *Holly Hill, supra. Lovvorn v. Miller,* (C.C.A. 5th, 1954) 215 F.2d 601.

Here, the Iowa Court did not need to await a "retrospective act" of the Secretary of HEW upon which to make a "respective judgment." Before the commencement of these cases, the Secretary had already promulgated the 1970 amendment, 20 C.F.R. 405.415(d)(3).

In some instances a different solution has been employed in reaching Congressional intent. If a regulation is "a clear departure from the statutory mandate," the judiciary will give force to the meaning of the Statute in spite of the regulation. *Oestereich v. Selective Service System Local Board,* (1968) 393 U.S. 233. Following this approach, the Court of Appeals for the 2nd Circuit took in *Kingsbrook Jewish Medical Center v. Richardson,* 486 F.2d 663 (C.A. 2, 1973) permitted a "suitable retroactive adjustment" in the absence of any pertinent regulation, after a Medicare regulation had been amended.

Respondent nursing homes are in no way penalized by the 1970 amendment. The retroactive adjustment of their operating costs in no way affected their cash flow nor their "out of pocket" expenses. They have no vested right in payments in excess of the "reasonable costs" limitation of "Part A of

Medicare" for they at all times were subject to a "suitable retroactive adjustment" if their actions in any manner resulted in excessive payments "for any fiscal period." 42 U.S.C. 1395x(v)(1). The Federal Act was part of their bargain under *Cornick v. Southwest Iowa Broadcasting Co.,* (Iowa, 1961) 107 N.W.2d 920, 921, and the "basis of payment" provision in the Handbook (App. H, pp. 28a - 29a)

In sum, Petitioners respectfully state that the Iowa Court was wrong when it said there was no regulation prior to August 1, 1970, which permitted a recapture of accelerated depreciation. Its decision is in complete disregard of the language of the Act and the proper application of the 1970 regulation which buttressed the Congressional intent. It was also wrong to suggest that the Iowa "law of contracts" bars its application even if other Courts view the regulations differently.

The legal issue here is of national importance as its scope is not limited to skilled nursing home situations. The principle of recapturing accelerated depreciation relates to all institutional providers in the Medicare Program, as well as in the Medicaid Programs adopting, as has Iowa, the Medicare formula.

It is further of grave importance for an early settlement of this issue in pending litigation. It will dispose of the pending litigation and controversies in the State of Iowa,[3] to say nothing of litigation in other states in which Medicaid operated under the Medicare formula in those years.

---

[3]At the present time within Iowa, 13 skilled nursing homes representing the sum of $83,950.00 are involved.

Further, it will be determinative of this identical issue in three Medicare cases in three different circuits of the United States Court of Appeals awaiting decisions.[4]

CONCLUSION

The Decision of the Iowa Court should not be permitted to stand as it is contrary to the spirit of the Federal Act, indeed the very language therein, and obstructs the Iowa Department from performing its duties thereunder.

For all the foregoing reasons, the Petitioners pray that a Petition for Writ of Certiorari be granted.

Respectfully submitted,

RICHARD C. TURNER
Attorney General of Iowa

LORNA LAWHEAD WILLIAMS
Special Assistant Attorney General

---

[4] *Hazelwood Chronic Convalescent Inc., v. Mathews (Weinberger),* No. 74-2210 9th Circuit Court of Appeals (awaiting decision)

South Windsor Convalescent Home Inc. v. Mathews (Weinberger), No. 75-6136, 2nd Circuit Court of Appeals (argument set for April 19, 1976)

Springdale Convalescent Center v. Mathews, No. 75-4199, 5th Circuit Court of Appeals (awaiting hearing date)

APPENDIX A

DECISIONS

236 N.W.2d 307

IOWÂ DEPARTMENT OF SOCIAL SERVICES, State of Iowa,
Appellant,

v.

WEST HEIGHT MANOR, INC., Appellee.

No. 2-56943.

Supreme Court of Iowa.

December 17, 1975.

McCORMICK, Justice.

This appeal requires us to determine the standard of payment for skilled nursing home services in the Iowa Medicaid program prior to July 1, 1970. We were confronted with a related problem in *Hutchison Nursing Home, Inc. v. Burns, Iowa,* 236 N.W.2d 312, filed separately this date. The determinative question in this case is whether the applicable payment rate for skilled nursing home services in the Iowa Medicaid program prior to July 1, 1970, was the customary charge of the nursing home or the Medicare reasonable cost formula adopted by Iowa in its Medicaid plan. The trial court held the basis for payment was the customary charge of the nursing home. We reverse and remand.

We described the Medicaid program in the *Hutchison* case, and that description will not be repeated here.

In March 1968, defendant became eligible to participate in the Medicaid program because of its certification as an extended care facility in the Medicare program. The state department of social services furnished defendant with documents explaining that nursing home services in the Medicaid program would be compensated under the Medicare reasonable cost formula. In addition, the department notified defendant by letter that the State would "apply the same standards and principles and use the same methods of computing payments currently applicable under Title XVIII (Medicare)." The department also informed defendant that, "The intent of the interim payment is to approximate your initial cost and minimize the amount of retroactive adjustment at the end of your reporting period." Ostensibly pursuant to the State's offer, defendant entered the Medicaid program by furnishing skilled nursing home services to Medicaid patients and complying with the State's record-keeping requirements.

Defendant participated in the Medicaid program in 1968, 1969, and 1970 but provided no Medicaid services after July 1, 1970. Interim payments for the services rendered were made in accordance with Medicare regulations and the state plan. At defendant's request the interim rate was fixed at $15 per patient per day. Over the period of defendant's participation, interim payments and credits of about $354,000 were made.

Based upon audit of defendant's cost records, the State claims defendant was overpaid a total of $59,158. That is the amount by which the annual computations based upon application of the Medicare reasonable cost formula were alleged to have been exceeded by the interim payments for the entire period involved.

When defendant rejected the State's claim, the State brought this action to collect the alleged overpayment, with interest. The State sued on a contract theory, alleging in effect that defendant breached its obligation to permit adjustment of payments, after audit, to conform them to the amounts determined under the Medicare reasonable cost formula.

In resisting the State's claim, defendant did not allege the department of social services ever promised to pay more than amounts fixed by the Medicare reasonalbe cost formula. Instead, defendants asserted the alleged contractual payment rate violated applicable state law, relying upon § 249A.4(9), The Code.

In relevant part that section provides:

> "Payment for other medical assistance under this chapter shall be the usual and customary fees, charges and rates, *provided, however, that if such payments are otherwise limited by federal law, such payment shall be as near the usual and customary fees, charges or rates as may be permitted by federal law."* (Italics added).

Defendant maintains federal law did not limit payments to less than its "usual and customary fees, charges and rates" during the period involved. It offered evidence that its customary charges exceeded the interim payment rate. Although there was contrary evidence, the trial court found this fact in defendant's favor. Since the court also decided the law in accordance with defendant's contention, the court found no overpayment had occurred and entered judgment for defendant.

In this context, the State's appeal requires us to interpret Code § 249A.4(9) in light of relevant federal law in order to

determine what payment rate it mandates and whether federal law imposed any limitation on such rate at the times involved in this case.

The first determination is obvious from the plain language of the statute. It requires payment for skilled nursing home services in the Medicaid program based upon "the usual and customary fees, charges and rates" unless limited by federal law. If they are limited by federal law, the payments are to be "as near the usual and customary fees, charges or rates as may be permitted by federal law."

We are unable to agree with the contention of the defendant and the holding of the trial court that federal law imposed no limitation upon payment fixed at nursing home usual and customary charges.

[1] The federal legislation established the Medicaid grant program expressly required state plans to

> "* * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services and to *assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.*" (Italics added). 42 U.S.C. § 1396a(a)(30).

We read this provision as a federal limitation on customary nursing home charges. We do not agree with defendant's assertion in its brief that this limitation is inherent in the Iowa statute. By reason of the limitation in the federal statute,

nursing homes in the Medicaid program could not make their customary charges for Medicaid patients if they exceeded "reasonable charges consistent with efficiency, economy, and quality of care."

[2] In developing its state plan Iowa decided the Medicare reasonable cost formula established a basis for determining reasonable charges for Medicaid services. Therefore, the State adopted that formula in its state plan, promulgated in its Medical Assistance Handbook for Skilled Nursing Homes, and incorporated it in departmental regulation 5.1(223), 1971 I.D.R. 944. Defendant contends the state plan provision, handbook reference, and regulation are all inconsistent with the mandate of § 249A.4(9), The Code, and thus invalid.

The first fallacy in this contention is defendant's assumption that § 249A.4(9) deems customary charges to be reasonable charges as the term "reasonable charges" is employed in the federal statute. The statute does not limit the "usual and customary payment to reasonable charges. Federal law imposes this limitation. Charges are not automatically reasonable just because they are customary.

The second fallacy in this contention is defendant's assumption that the Medicare reasonable cost formula as adopted by Iowa in 1967 as its standard for Medicaid payments does not provide a basis for ascertaining reasonable charges. The formula is designed to arrive at a reasonable rate of compensation. The provider of services is first reimbursed for all of its costs attributable to its Medicaid patients. Actual, current costs are used. 20 C.F.R. § 405.402(a). This is the reason settlements are delayed until after audit. Even then, a fixed percentage is added to recognized costs to be sure all costs are covered. 20 C.F.R. § 405.402(e) (1966). Profitmaking facilities are assured what Congress deems to be a fair rate of return on their equity

capital as profit. The profit rate is "one and one-half times the average long-term rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund." 20 C.F.R. § 405.402(f); cf. 42 U.S.C. § 1395x(v)(1)(A), (B).

In developing its state plan, Iowa was guided by the HEW department's Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs. That publication reflected departmental interpretation of the reasonable charges limitation of 42 U.S.C. § 1396a(a)(30). It provided in relevant part:

> "For institutions, other than hospitals, the fee structure will focus on payment on a reasonable cost basis determined according to commonly used accounting methods on a per diem or relationship of costs to charges basis. For comparable facilities, payment equivalent to reasonable costs under part A of title XVIII is recommended." Handbook of Public Assistance Administration, Supplement D, *supra*, § D-5340.

Defendant accurately points out that the Medicare reasonable cost formula was not federally established by regulation as a method for computing the upper limit of Medicaid payments until July 1, 1970. See 45 C.F.R. § 250.30(b)(3)(ii). We agree. However, it is one thing to say it was not the measure of maximum payments until then and quite another to say it was not an appropriate means of computing reasonable charges before then.

In 1967, the State was legitimately interested in adopting a Medicaid payment standard which would conform with the federal statutory reasonable charges limitation. The Medicare formula provided such a standard, and HEW recommended it. This standard provided the State with an appropriate means of enforcing the federal limitation on customary nursing home charges.

The effect of the secretary of HEW's July 1, 1970, adoption of 45 C.F.R. § 250.30(b)(3)(ii) was to limit Medicaid payments to the reasonable cost standard of Medicare. This means the problem in the present case should not recur. It also buttresses our holding that the state department of social services appropriately adopted the Medicare reasonable cost formula earlier as a proper basis for computing reasonable charges within the meaning of that federal statutory limitation upon the payment of customary nursing home charges. In adopting regulation 45 C.F.R. § 250.30(b)(3)(ii), the HEW secretary necessarily made a similar determination that the Medicare reasonable cost formula established reasonable charges within the meaning of 42 U.S.C. § 1396a(a)(30). His authority to do so was challenged by several nursing homes in *Johnson's Professional Nursing Home v. Weinberger*, 490 F.2d 841 (5 Cir. 1974). In deciding the issue, the court said:

> "Opelika cannot and does not assert that establishment of payment limits is outside the Secretary's authority, rather the nursing homes contend that by limiting the Medicaid nursing home payments to 'reasonable costs' (the Medicare standard) when the Medicaid statute limits the payments to 'reasonable charges consistent with efficiency, economy and quality of care' the Secretary acted inconsistently with his statutory command. We recognize, that 'reasonable costs' and 'reasonable charges' may have distinct and different connotations in common understanding, but the issue here, as recognized by the district court, is whether reasonable costs as defined in the complex formulae of Title XVIII (Medicare) is consistent with the Medicaid statutory requirement of reasonable charges consistent with efficiency, economy, and quality of care.
>
> "Nothing in the statutory scheme or in the statutory history indicates that Congress meant to preclude the reasonable cost standard as a measure of reasonable charges consistent with efficiency, economy, and quality of care. The statutory limit, reasonable charges, etc., applies to all

state Medicaid payments. But in 42 U.S.C.A. § 1396a(a)(13)(D), Congress specified that inpatient hospitals should receive reasonable costs under Medicaid. Thus Congress itself seemingly used 'reasonable costs' as a standard consistent with the general statutory limit.

"* * *

"Congress has formulated a comprehensive formula for reimbursing nursing homes under Medicare, under which nursing homes furnish the same services as under Medicaid. It was not inconsistent with the Medicaid standard for the Secretary to promulgate a regulation which adopted the standard Congress had promulgated to achieve the same purposes." 490 F.2d 841 at 844-845.

We reach a similar conclusion for similar reasons in upholding the 1967 adoption by the Iowa department of social services of the Medicare reasonable cost formula as the basis for Medicaid reasonable charge payments. Congress and the HEW secretary at that time treated the reasonable cost formula as a proper basis for determining reasonable charges. It was not the only way, but it was an appropriate way. It was mandated in Medicare, and it was permissible in Medicaid.

Adoption of the Medicare standard did not violate Iowa law. In § 249A.4(9), The Code, the legislature incorporated the federal reasonable charges limitation on the payment of customary charges. In adopting the Medicare standard in its state plan and regulations, the department of social services did no more than give effect to that federal limitation.

Defendant's reliance upon *Seneca Nursing Home v. Kansas State Bd. of Social Welf.*, 490 F.2d 1324 (10 Cir. 1974), is misplaced. The question in *Seneca* was whether a regulation of the Kansas department of social welfare providing an allowable cost plus fixed fee formula for Medicaid payments violated a

Kansas statute requiring Medicaid payments to be "reasonable, usual and customary charges." The Kansas regulation and statute were materially different from those involved here. The Kansas regulation did not incorporate the Medicare reasonable cost formula, and it permited budget limitations to affect the fixed fee which could be paid. The Kansas statute limited payments to reasonable charges, not merely usual and customary charges. The *Seneca* court was confronted only with an issue of conflict between the Kansas regulation and the Kansas statute. The consistency between the Medicare reasonable cost formula and the federal reasonable charges standard was not involved in that case.

[3] We find no conflict between Code § 249A.4(9) and use by the Iowa department of social services of the Medicare reasonable cost formula as the basis for fixing reasonable charges to pay nursing homes for Medicaid services.

Defendant is thus entitled to no more than its contract with the State calls for, adjustment of the amounts received as interim payments to the amount established under the Medicare reasonable cost formula. The record shows the State claimed $59,158 in Medicaid overpayments, with interest.

[4] Of the principal amount, $18,095 is attempted recapture of depreciation. This is the amount by which the depreciation taken by defendant in the Medicaid program exceeded the amount it would have taken had the straight-line method been used. The State seeks to recapture this amount because defendant terminated participation in Medicaid before exhaustion of the useful life of its depreciable assets. In *Hutchison Nursing Home, Inc. v. Burns, supra,* we held the Medicare reasonable cost formula as it existed prior to August 1, 1970, did not authorize the State to recapture accelerated depreciation in these circumstances. Therefore, for the reasons

given in that opinion, the State is not entitled to the portion of its claim attributable to accelerated depreciation. Accordingly, the total overpayment for the period involved, based upon application of the Medicare formula without depreciation recapture, is $41,063.

Upon remand, the trial court shall enter judgment for the principal amount of $41,063 and interest at the legal rate of seven percent from the date of procedendo from this court.

Reversed and remanded.

APPENDIX B

HUTCHISON NURSING HOME, INC.,
et al., Appellees,

v.

Kevin BURNS, Acting Commissioner of State of Iowa, Department of Social Services, and State of Iowa Department of Social Services, Appellants.

No. 2-57121.

Supreme Court of Iowa.

December 17, 1975.

McCORMICK, Justice.

This appeal involves Iowa's medical assistance program for the needy, "Medicaid", established in chapter 249A, The Code. Plaintiff nursing homes brought a certiorari action in district court challenging a decision of defendant commissioner that the department of social services had a right to recapture portions of depreciation taken by the nursing homes when they participated in the Medicaid program. The trial court sustained the writ. We affirm.

The question here, as it was in the trial court, is a legal one. It is whether plaintiffs' participation in the Medicaid program was subject to an unarticulated but implicit condition that if they terminated their participation in the program before exhaustion of the useful life of their depreciable assets they would be obligated to reimburse the State for accelerated depreciation. The State's claim for reimbursement equals the amount by which the depreciation plaintiffs actually took

during the period of their participation exceeded the depreciation they would have taken during that period if they had used the straight-line method. The same question is involved in *Iowa Department of Social Services v. West Height Manor, Inc.*, 236 N.W.2d 307, filed separately this date.

The parties are agreed on the amounts of accelerated depreciation involved:

Hutchison Nursing Home, Inc.	$6049
New Haven Rest Home, Inc.	$3494
Griffin Nursing Center	$8809

We will first outline the nature and terms of the Medicaid program to put the question in context. Then plaintiffs' participation in the program will be examined. With that background, the question will be answered.

The federal government made grants available to the states for state-administered medical assistance programs by legislation enacted in 1965, effective in 1967. 42 U.S.C. § 1396 et seq. This legislation is Title XIX of the Social Security Act. It requires implementing state legislation, contemplates appropriation of state funds, and provides a number of conditions which states must meet to be eligible for the grants involved. These conditions must be met in a "state plan" submitted to and approved by the Secretary of Health, Education, and Welfare. The federal medical assistance program differs from Medicare, established in Title XVIII of the Social Security Act, in that Medicare provides medical assistance to the aged and is entirely federally funded and administered. However, the Medicare and Medicaid programs have the purpose of providing the same kinds and quality of medical assistance to those eligible to receive it, and they have a number of administrative similarities

because of that common purpose.

Iowa participates in Medicaid by reason of an enabling act which became effective July 1, 1967. Acts 62 G.A. ch. 223. Subsequently, Iowa submitted its state plan to the HEW secretary for approval. One of the federal requirements was that the state plan provide methods and procedures governing payment for Medicaid services to assure that payments were "not in excess of reasonable charges consistent with efficiency, economy, and quality of care; * * *." 42 U.S.C. § 1396a(a)(30). In relevant part, the Iowa plan provided:

> "Basis of payment for skilled nursing homes is 'reasonable cost' using the same standards and principles and methods of computing payments *currently applicable* to extended care facilities under Title XVIII [Medicare]." (Italics added).

The Iowa plan was approved on September 27, 1967. The Medicare "reasonable cost" formula which was then applicable remained the same until Medicare regulations were changed August 1, 1970. See 20 C.F.R. §§ 405.401-405.454, effective November 12, 1966. Thus, the Iowa plan adopted the Medicare formula as it existed in 1967 and continued to exist until August 1, 1970, as the formula for Iowa Medicaid payments.

This reimbursement principle was included in the Medical Assistance Handbook for Skilled Nursing Homes, prepared and promulgated by the defendant department of social services to plaintiffs and other nursing homes seeking certification to participate in the Medicaid program. This principle was later incorporated in departmental regulation 5.1(223) adopted March 11, 1970. 1971 I.D.R. 944.

Plaintiffs entered the Medicaid program in 1967. The

parties agree the relationship between plaintiffs as participants in the Medicaid program and the State as its administrator was a contractual one. Plaintiffs had to meet certain certification standards. Annual licensing was provided for. Plaintiffs had to promise to keep certain records which the State would subject to regular audit to determine reimbursement entitlement.

It is undisputed that at all material times plaintiffs were to provide skilled nursing home services to Medicaid patients in return for payment under the reasonable cost formula employed in 1967 Medicare regulations.

The Medicaid program was administered by the State through an intermediary. Blue Cross and Blue Shield. The intermediary had the responsibility of computing the Medicaid payments due the nursing homes under the Medicare formula. The computation was made annually after an audit of the financial records of each nursing home. Before that audit, the nursing homes were given tentative payments based upon estimated reasonable charges. After the audit, adjustments were made through refund or additional payment to bring the amounts paid into balance with the amount due under the Medicare formula.

Plaintiff Hutchison Nursing Homes, Inc., terminated its participation in the Medicaid program February 1, 1971. New Haven Rest Home, Inc., terminated October 1, 1970, and Griffin Nursing Center terminated April 1, 1972.

The State, through its intermediary, had made final settlement based on audit of nursing home books for each of the years 1967, 1968, 1969, and 1970, with each of the plaintiffs. For each of those years the intermediary computed payments in accordance with the 1967 Medicare formula. That formula was contained in federal regulations, 88

405.401-405.454, Subpart D of Part 405, Title 20, Code of Federal Regulations, effective with publication in the Federal Register on November 22, 1966. Under that formula, reimbursement for care was based upon reasonable costs as defined in the regulations, including a fixed rate of return on the equity capital of profit-making proprietary facilities. The regulations expressly provided that in computing allowable costs, "In general, the options for accelerated depreciation allowed by the income tax laws will be permitted." § 405.402(d). In addition, the regulations contained this relevant language:

> "§ 405.415 Depreciation: allowance for depreciation based on asset costs.
>
> (a) *Principle.* An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:
>
> (1) Identifiable and recorded in the provider's accounting records;
>
> (2) Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets, and;
>
> (3) Prorated over the estimated useful life of the asset using:
>
> (i) The straight-line method; or
>
> (ii) Accelerated depreciation, under a declining balance method (not to exceed double the straight-line rate) or the sum-of-the-years' digits method * * *
>
> (b) * * *
>
> (4) *Declining balance method.* Under the declining balance method, the annual depreciation allowance is

computed by multiplying the undepreciated cost of the asset each year by a uniform rate up to double the straight-line rate."

Plaintiffs used the declining balance method of depreciation as permitted by the regulations. The intermediary approved the depreciation amounts claimed for each year as an allowable cost in computing annual Medicaid payments as required by the regulations. The final payments for the years 1967, 1968, 1969, and 1970 were made on that basis.

No provisions appeared in the Medicare regulations effective when Iowa's state Medicaid plan was approved, its handbook promulgated, or its departmental regulation 5.1 adopted, which purported to authorize retroactive recapture of amounts attributable to accelerated depreciation if a nursing home would withdraw from the Medicare program before exhaustion of the useful life of depreciable assets. The present controversy arose precisely because the State attempted to offset such recaptured depreciation against amounts separately due plaintiffs after their termination of participation in the Medicaid program.

The State contends the right to recapture accelerated depreciation inheres in the reasonable cost concept. This contention ignores the import of the fact the applicable regulations defining reasonable cost did not mention any such right. If it had been the intent of the HEW secretary to qualify a facility's right to use accelerated depreciation as an allowable cost for reimbursement purposes, such intention could easily have been expressed in the regulations.

The secretary subsequently demonstrated how the subject could have been regulated. Effective August 1, 1970, the Medicare regulations were amended. The use of accelerated

depreciation was restricted. This language was added to 20 C.F.R. § 405.415(d)(3):

"When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years."

[1,2] The State argues that this amendment was a mere "clarification" of the prior meaning of reasonable cost. We disagree. We recognize that an amendment to a statute or regulation may indicate either an intent to change the existing law or merely to clarify it, depending upon the circumstances. *Hansen v. Iowa Employment Security Commission,* 239 Iowa 1139, 1141-1142, 34 N.W.2d 203, 205 (1948). We have no basis in the circumstances here to find the 1970 amendment was a mere administrative interpretation of the original regulations. The amendment's limitation on the right to use accelerated depreciation as an allowable cost is inconsistent with the express definition of accelerated depreciation as an allowable cost without limitation in the original regulations. We are compelled to the conclusion the amendment was a substantive change in the rules governing computation of reasonable costs

under the Medicare formula. This conclusion is buttressed by the fact that other parts of the amendment changed the circumstances under which accelerated depreciation could be taken. We are unable and unwilling to alter the plain meaning of the original regulations under the guise of interpretation.

[3,5] The State characterizes the result as a windfall to those facilities which terminated participation in the program before exhaustion of the useful life of their depreciable assets. There are at least two answers to this characterization. One is the fact it is based upon an assumption that the assets did not actually depreciate at the accelerated rate. The record does not support this assumption. Considerable evidence was offered to the contrary. The other answer is that the regulations may not be changed by interpretation simply because they result in a benefit to plaintiffs which the State considers undesirable. The State must abide by the terms of its contracts. *Kersten Company Inc. v. Department of Social Services,* 207 N.W.2d 117 (Iowa 1973).

At least one federal district court has recognized the 1970 amendment changed and did not simply clarify the meaning of the 1967 regulations. See *South Windsor Convalescent Home, Inc. v. Weinberger,* 403 F.Supp. 515 (1975). In that case the court also held it was a denial of due process for the federal government to apply the amendment retroactively in the Medicare program to recapture accelerated depreciation taken under the original regulations.

[6] We interpret the Medicare formula as it existed before August 1, 1970, to include accelerated depreciation as an allowable cost not subject to government recapture upon nursing home termination of participation in the Medicare program. As a result, the Iowa Medicaid payment formula also included accelerated depreciation as an allowable cost not

subject to government recapture upon nursing home termination of participation in the Medicaid program. This is the formula which was in effect at all material times in this case.

Whatever the rights of the federal government in the Medicare program to recapture accelerated depreciation through retroactive application of the August 1, 1970, change in the Medicare formula, no corresponding rights accrued to the State of Iowa in the Medicaid program. The August 1, 1970, change was not part of the State's bargain with these plaintiffs, nor was it part of the state law and state plan under which that bargain was made and performed.

The trial court was right in holding the State was not entitled to recapture the claimed amounts of accelerated depreciation from plaintiffs. The writ of certiorari was properly sustained.

Affirmed.

APPENDIX C

CONSTITUTION OF THE UNITED STATES

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

APPENDIX D

UNITED STATES CODE

42 U.S.C. § 1395f

Reasonable cost of services

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1395e of this title, be the reasonable cost of such services, as determined under section 1395x(v) of this title.

42 U.S.C. § 1395x

Reasonable cost; semi-private accommodations

(v) (1) The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceeding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in

different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. *Such regulations shall* (1) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and *(B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.* Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including neccessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. [Emphasis Supplied]

42 U.S.C. § 1396a

(a)(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization

of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

APPENDIX E

CODE OF FEDERAL REGULATIONS

20 C.F.R. 405.415

1966 Regulations published in 31 Federal Register 14,810, 14,811, November 22, 1966.

"405.415 Depreciation: allowance for depreciation based on asset costs.

(a) *Principle.* An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: . . .

(3) Prorated over the estimated useful life of the asset using the straight-line method or accelerated depreciation under the declining balance or sum-of-the-years' digits methods.

(d) *Depreciation methods.*

(1) Proration of the cost of an asset over its useful life will be allowed on the straight-line, the declining balance, or the sum-of-the-years' digits methods. . . .

(f) *Gains and losses on disposal of assets.* Gains and losses realized from the disposal of depreciable assets are to be included in the determination of allowable cost. The extent to which such gains and losses are includable is to be calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation in the program."

Amendment to 20 C.F.R. 405.415

1970 Regulations published in 35 Federal Register page 12331, August 1, 1970.

"405.415 (d) *Depreciation methods.* (1) Proration of the cost of an asset over its useful life is allowed on the straight-line method, or, where permitted under § 405.415(a)(3), the declining balance or the sum-of-the-years' digits methods. One method may be used on a single asset or group of assets and another method on others. In applying the declining balance or sum-of-the-years' digits method to an asset that is not new, the undepreciated cost of the asset is treated as the cost of a new asset in computing depreciation.

(3) When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years."

APPENDIX F

CODE OF IOWA

§ 249A.4

Duties of commissioner. The commissioner shall be responsible for the effective and impartial administration of this chapter and shall, in accordance with the standards and priorities established by this chapter, by applicable federal law, particularly Title XIX of the United States Social Security Act (Title XLII, United States Code, sections 1396 to 1396g), as amended to January 1, 1973, by the regulations and directives issued pursuant thereto, and by the state plan approved in accordance therewith, . . .

9. . . . Payment for other medical assistance under this chapter shall be the usual and customary fees, charges and rates, provided, however, that if such payments are otherwise limited by federal law, such payment shall be as near the usual and customary fees, charges or rates as may be permitted by federal law.

APPENDIX G

IOWA DEPARTMENTAL REGULATIONS

1971 I.D.R.

4.12 *Skilled nursing homes.* Payment will be approved for care in skilled nursing homes providing skilled nursing care is medically necessitated by the recipient's condition. The definition of "skilled nursing care" is identical to that in effect for extended care beneficiaries in the Medicare Program.

5.1 *Principles governing reimbursement of providers of medical and remedial care.* Payment for services of providers of care participating in the medical assistance program will be made on the basis of "reasonable cost" for institutional providers (hospitals and skilled nursing homes). The determination of reasonable cost for institutional providers will be made utilizing the methods and criteria in effect for these providers in the Medicare program. (Title XVIII of the Social Security Act)

APPENDIX H

IOWA'S STATE PLAN

Attached to the form submitted to HEW seeking approval of Iowa's State Plan in July, 1967, and approved September 27, 1967, (effective date July 1, 1967) were the following documents:

Explanatory statement:

"Basis of payment for skilled nursing homes is 'reasonable cost' using the same standards and principles and methods of computing payments currently applicable to extended care facilities under Title XVIII [Medicare]."

IOWA DEPARTMENT OF SOCIAL SERVICES HANDBOOK FOR SKILLED NURSING HOMES

The "Basis of Payment" provision appearing on page 3 of the July, 1967 edition (renumbered page 7 in the August, 1967, revised edition which reads:

Basis of payment for services:

Basis of payment for care furnished by skilled nursing homes will be the usual, customary and reasonable charges of the facility. However, total payments to the facility through the Medical Assistance program during any fiscal year may not exceed the *reasonable cost of operation of the facility.* In determination of the reasonableness of cost the principles of reimbursement for extended care facilities *under Part A of Medicare are applicable.* The relationship of charges to costs will be determined by the Carrier on an annual basis by an audit of the financial records of each skilled nursing home. If charges to the Medical Assistance program during the period of the audit exceed allowable

costs the facility will be required to refund the overpayment to the Carrier.

In order to prevent excessive reimbursements, which would result in the necessity of a refund, the facility may wish to submit cost data based on the previous years operation which will enable the Carrier to compute an appropriate rate of payment based on the principles of reimbursement, Thus minimizing the amount of retroactive adjustment. In the case of extended care facilities participating in Part A of Medicare the Interim rate established for the facility in that program will be utilized by the Carrier for Medical Assistance in payment of claims.

Skilled Nursing Homes, other than those certified as extended care facilities, will be provided on request by the Carrier with information concerning the principles of reimbursement and the cost data, which must be submitted if the facility wishes an interim rate of payment to be established.